

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1945

01930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Mary's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
<u>X</u> TOWN <u>Rural Drayden</u>		<u>Life</u>		TOWN <u>Rural Drayden</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Joseph A. Barnes</u>				OF DEATH: <u>Feb. 11 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
		<u>Married</u>		<u>Feb. 25, 1875</u>		<u>79</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		11. BIRTHPLACE (State or foreign country):	
<u>Labor</u>		<u>Daywork</u>		<u>yes</u>		<u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY?	
						<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John A. Barnes</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>9</u> # <u>1</u>				<u>11-11-11-11-11-11</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Josephine Barnes Drayden, Md.</u>				DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE			
				<u>421.4</u>			
				ANTECEDENT CAUSE (B):			
				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
				(A) <u>Chronic Valvular Heart Disease</u>			
				DUE TO			
				(B) <u>Coronary Embolism</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
						21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
						21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov</u> , 1950, to <u>Feb 11</u> , 1955, that I last saw the deceased alive on <u>Feb 10, 1955</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>P. J. Beary M.D.</u>				ADDRESS <u>Great Mills, Md.</u>			
DATE SIGNED <u>2-12-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/15/55</u>		<u>St Marks</u>		<u>Valley Lee Md.</u>	
DATE REC'D. BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 13/56</u>		<u>P. J. Beary M.D.</u>		<u>Jos. C. Mattingley</u>		<u>Leonardtown, Md.</u>	

BUREAU V. S.

SEP 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01932
1946 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St Marys</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>St Marys</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St Georges Island</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St Marys Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <u>Howard J. Chesser</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb 18 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Sept-1-1885</u>	
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Waterman</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland St Marys</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William O. Chesser</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Worton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>g</u>				16. SOCIAL SECURITY NO. <u>Mr Howard J. Chesser</u>			
17. INFORMANT & ADDRESS: <u>Mr Howard J. Chesser</u>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u>				DUE TO <u>Uremia</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic C V disease</u>				DUE TO <u>5 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Coronary thrombosis</u>							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1 week</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Feb 11, 1955</u> , to <u>Feb 18, 1955</u> , that I last saw the deceased alive on <u>Feb 18, 1955</u> , and that death occurred at <u>5:50</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Way Luther</u>				ADDRESS <u>Mechanicville Md 21915</u>			
DATE SIGNED <u>2/20/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Feb 21-55</u>			
NAME OF CEMETERY OR CREMATORY <u>M.E. Methodist</u>				LOCATION (City, town, or county) (State) <u>St Georges Island, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>2/20/55</u>				REGISTRAR'S SIGNATURE <u>P. H. Bean</u>			
24. FUNERAL DIRECTOR <u>Jos C Mattingley</u>				ADDRESS <u>Leonardtown Md</u>			

MARGIN RESERVED FOR BINDING

V.S. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1955

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01933

CERTIFICATE OF DEATH

Reg. Dist. No. 282

Item 9 Filed 3-7-55 at

1. PLACE OF DEATH COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hermansville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hermansville, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3 Natch Road</u>		STREET ADDRESS (If rural, give location) <u>3 Natch Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Beulah</u> (Middle) <u>Virginia</u> (Last) <u>Gross</u>	4. DATE OF DEATH	(Month) <u>2</u> (Day) <u>28</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/1/06</u>
9. AGE last birthday <u>48</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Senora P. Nicholas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>193-22-3924</u>	
17. INFORMANT AND ADDRESS <u>Harriet B. Coleman - Sister</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
170X Immediate cause		1 hr.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		2 day	
(a) <u>Respiratory Depression</u>		1 wk.	
(b) <u>Pulmonary Edema</u>		2 yrs.	
(c) <u>Progressive Cardiac Failure</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
<u>Carcinoma of Rt. Breast & Metastasis</u>			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>	(CITY OR TOWN) <u>None</u>	(COUNTY) <u>None</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At-work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>Aug. 15, 1955</u> to <u>Feb. 28, 1955</u> , that I last saw the deceased alive on <u>Feb. 26, 1955</u> and that death occurred at <u>8:00 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Henry B. Johnson, M.D.</u>		DATE SIGNED <u>2/28/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-3-55</u>	NAME OF CEMETERY OR CREMATORY <u>St Peter's Claver</u>
LOCATION (City, town, or county) <u>St Mary's Md</u>		24. FUNERAL DIRECTOR <u>P.E. Sewell, Pr. Frederick</u>	
DATE REC'D BY LOCAL REG. <u>3/3/55</u>		REGISTRAR'S SIGNATURE <u>Robt. J. Locke</u>	

md

RECEIVED

MAR 4 1955

BUREAU V. 3

1948

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St. Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St. Mary's</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lexington Park</i>		LENGTH OF STAY (in this place) <i>10 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lexington Park</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Haynes Donley Hart</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>2 27 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Cauc.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>3-28-1906</i>	
9. AGE last birthday: <i>48</i> yrs.		10. MONTHS: <i>11</i>		11. DAYS: <i>11</i>		12. HOURS: <i>11</i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Electrician</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Industrial</i>		11. BIRTHPLACE (State or foreign country): <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME: <i>John F. Hart</i>				14. MOTHER'S MAIDEN NAME: <i>Minnie Lee Tigue</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No.: <i>233-07-4168</i>		17. INFORMANT & ADDRESS: <i>Leonard Cochran Jr., Tall Timber, Md.</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
421.4 Immediate cause (a) <i>Cerebral embolism</i>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Chronic Valvular Heart Disease</i>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>0</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>September 25</i> , to <i>2-27</i> , 1955, that I last saw the deceased alive on <i>Feb 24 1955</i> , and that death occurred at <i>3 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>P. J. Bean, M.D.</i>				ADDRESS <i>Great Mills Md</i>		DATE SIGNED <i>2-28-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		DATE THEREOF <i>March 3, 55</i>		NAME OF CEMETERY OR CREMATORY <i>Wood Cemetery</i>		LOCATION (City, town, or county) (State) <i>West Va.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-28-1955</i>		REGISTRAR'S SIGNATURE <i>P. J. Bean, M.D.</i>		24. FUNERAL DIRECTOR <i>George Cook, Cedar Groove, W. Va.</i>		ADDRESS	
Local Registrar							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 1 1955

BUREAU V. S.

1949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Leonardtown</i>		<i>10</i>		OR TOWN <i>Maddot</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St Mary's Hospital</i>				STREET ADDRESS (If rural give location) <i>—</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Mary Rose Louise Herbert</i>				<i>Feb 7 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	10. UNDER 1 YEAR	11. UNDER 24 HRS.	12. CITIZEN OF WHAT COUNTRY?
<i>Female</i>	<i>Colored</i>	<i>Widowed</i>	<i>July 29-1877</i>	<i>77</i> yrs.	<i>7</i> Months	<i>11</i> Days	<i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:			
<i>House wife</i>				<i>St Mary's Co ind</i>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Joseph Forest</i>				<i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>g</i>				<i>Richard Billingsley Herbert</i>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<i>Maddot Md</i>				19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
I				331X IMMEDIATE CAUSE			
(A)				<i>Cerebral Vascular accident</i>			
ANTECEDENT CAUSE (S)				DUE TO			
(B)				<i>Arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				<i>2 wk</i>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/19</i> , 1955, to <i>2/7</i> , 1955, that I last saw the deceased alive on <i>2/5</i> , 1955, and that death occurred at <i>1045</i> M, from the causes and on the date stated above.							
SIGNATURE <i>MD Boyd</i>				DATE SIGNED <i>2/7/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR			
<i>Burial</i>				<i>Dr C. Mattingsley Leonardtown</i>			
DATE REC'D BY LOCAL REGISTRAR <i>4/7/55</i>				REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1954
BUREAU V. S.

01937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1950

CERTIFICATE OF DEATH

Reg. Dist. No. 281

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St Mary's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St Mary's</i>
CITY <i>Hollywood</i>	LENGTH OF STAY <i>3 months 4 days</i>	CITY <i>Hollywood</i>	CITY <i>Hollywood</i>
TOWN <i>Hollywood</i>		TOWN <i>Hollywood</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<i>John Francis Latham</i>		<i>Feb. 28</i>	<i>1955</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Nov. 23 1954</i>
9. AGE last birthday <i>5 yrs 3 mos 4 days</i>		10. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>George Wallace Latham</i>		14. MOTHER'S MAIDEN NAME: <i>Violet Elizabeth Heard</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS: <i>George W. Latham Hollywood, Md.</i>		18. MEDICAL CERTIFICATION:	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 25</i> , 19 <i>55</i> , to <i>Feb 28</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Feb 27</i> , 19 <i>55</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<i>Burial</i>	DATE THEREOF <i>3/1/55</i>	NAME OF CEMETERY OR CREMATORY <i>St Aloysius</i>	LOCATION (City, town, or county) (State) <i>Lionardtown, Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>Feb 28/55</i>	REGISTRAR'S SIGNATURE <i>J. P. Ryan</i>	ADDRESS <i>Mr. C. Mattingly Lionardtown, Md.</i>	

U. S. A.

1944

1951

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>St Mary's</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>St Mary's</i>	
CITY (If outside corporate limits, write name of nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write name of nearest town)		OR TOWN	
X <i>Compton</i>		<i>65 yrs</i>		<i>Compton</i>		<i>1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Julen Lucas</i>				<i>Feb. 3 1955</i>			
5. SEX. <i>Female</i>		6. COLOR OR RACE. <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <i>Widow</i>		8. DATE OF BIRTH. <i>Feb. 2 1860</i>	
9. AGE last birthday <i>95</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>A. L. Martin</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service.) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT'S ADDRESS <i>Sidney Lucas Compton, Md</i>				18. MEDICAL CERTIFICATION			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <i>Fibrillation of heart</i>				<i>eye</i>			
ANTECEDENT CAUSE (B) <i>Bronchitis & loss of appetite</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION. <i>U</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M.)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased <i>many yrs ago</i> , 19 <i>1900</i> , and that death occurred at <i>8:00 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J. F. Freeman</i>				DATE SIGNED <i>Feb 5 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				24. FUNERAL DIRECTOR <i>Leonardtown Md</i>			
DATE REC'D BY LOCAL REGISTRAR <i>Feb 5 1955</i>				REGISTRAR'S SIGNATURE <i>Robt. J. Locke</i>			
25. FUNERAL DIRECTOR <i>Joe C. Mallinquey</i>				ADDRESS <i>Leonardtown Md</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUKHAU V. 81

1985 12



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1952

01939

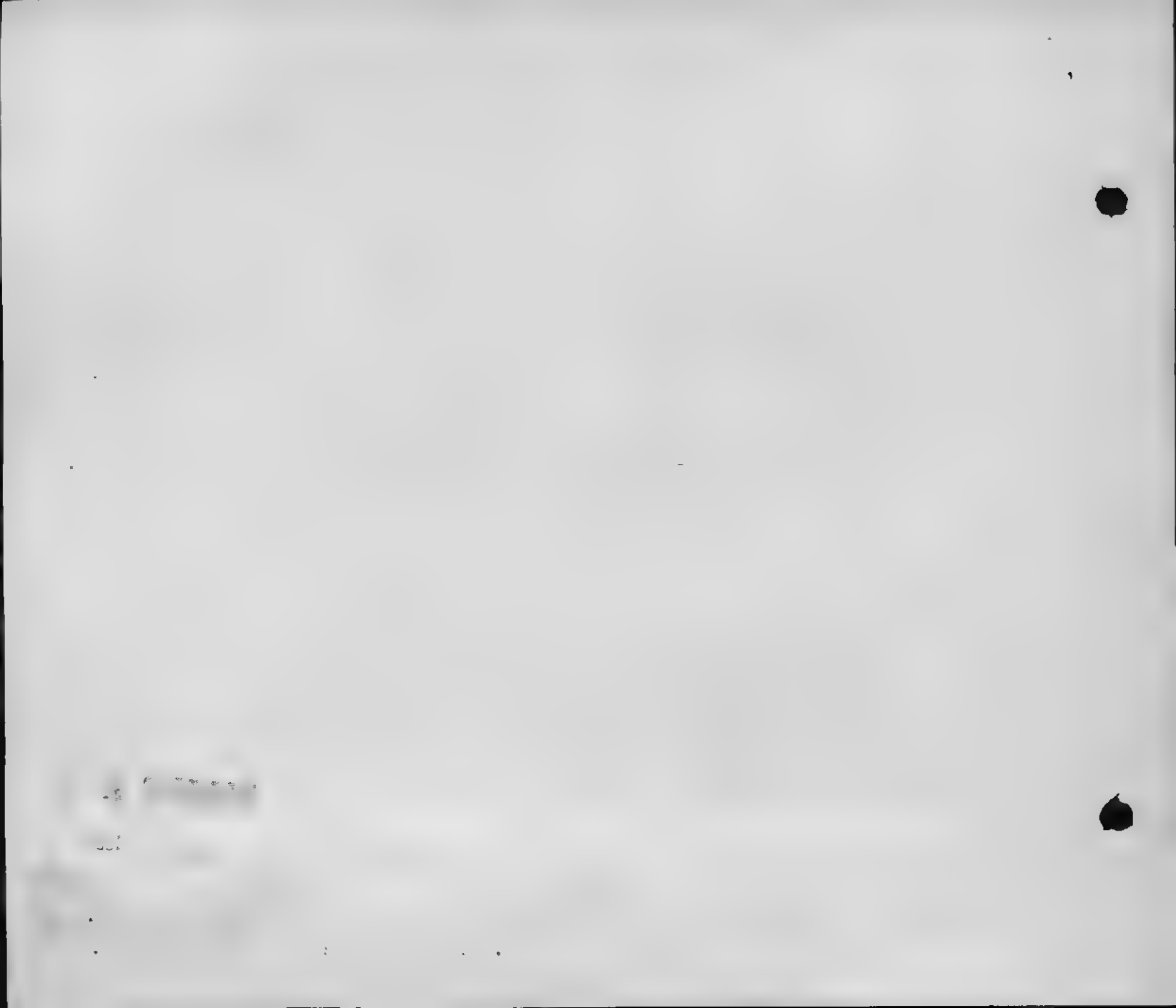
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Saint Mary's		MARYLAND		STATE Maryland		COUNTY Saint Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Mechanicsville				TOWN Mechanicsville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				Rural			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
William		Isaac		Lyles		February 19, 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Negro		Married		1900	
9. AGE last birthday:		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
54 yrs.		Tenant		Farm		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
U.S.A.		Clarence Lyles		Catherine Jenifer			
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
229-16-3645		Florine Lyles :::: Mechanicsville, Md.		I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		(a) Immediate cause	
19. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
None		Cerebral hemorrhage					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		run over by trailer truck		Mechanicsville H. Mary's Dist		2 19 55 55	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		CHIEF MEDICAL EXAMINER	
		fell off trailer & run over by trailer		SIGNATURE		DEPUTY MEDICAL EXAMINER	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/23/55		All Faith Cemetery		Charlotte Hall, Md.	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-23-1955		Robert G. Locke		P. B. Robinson :::: Leonardtown, Md.			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1953

CERTIFICATE OF DEATH

Reg. Dist. No.

019411

282

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St. Mary's</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>	LENGTH OF STAY (In this place) <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Guiana C.</u>	(Middle) <u>Marie</u>	(Last) <u>Marie</u>	DATE OF DEATH <u>Feb 14 1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 12 1904</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME: <u>Joseph J.</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mr. John M. Senior Leonardtown, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE		(A) DUE TO <u>Cerebrovascular accident.</u>	
ANTECEDENT CAUSE (S)		(B) DUE TO <u>Hypertensive cardiovascular disease.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21G. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> to <u>Feb.</u> , 19 <u>55</u> that I last saw the deceased alive on <u>14 Feb. 1955</u> and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR <u>2-16-55</u>		ADDRESS <u>Leonardtown, Md.</u>	
REGISTRAR'S SIGNATURE <u>R. F. Locke</u>		DATE SIGNED <u>2/15/55</u>	

RECEIVED

1961

10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1954

01947

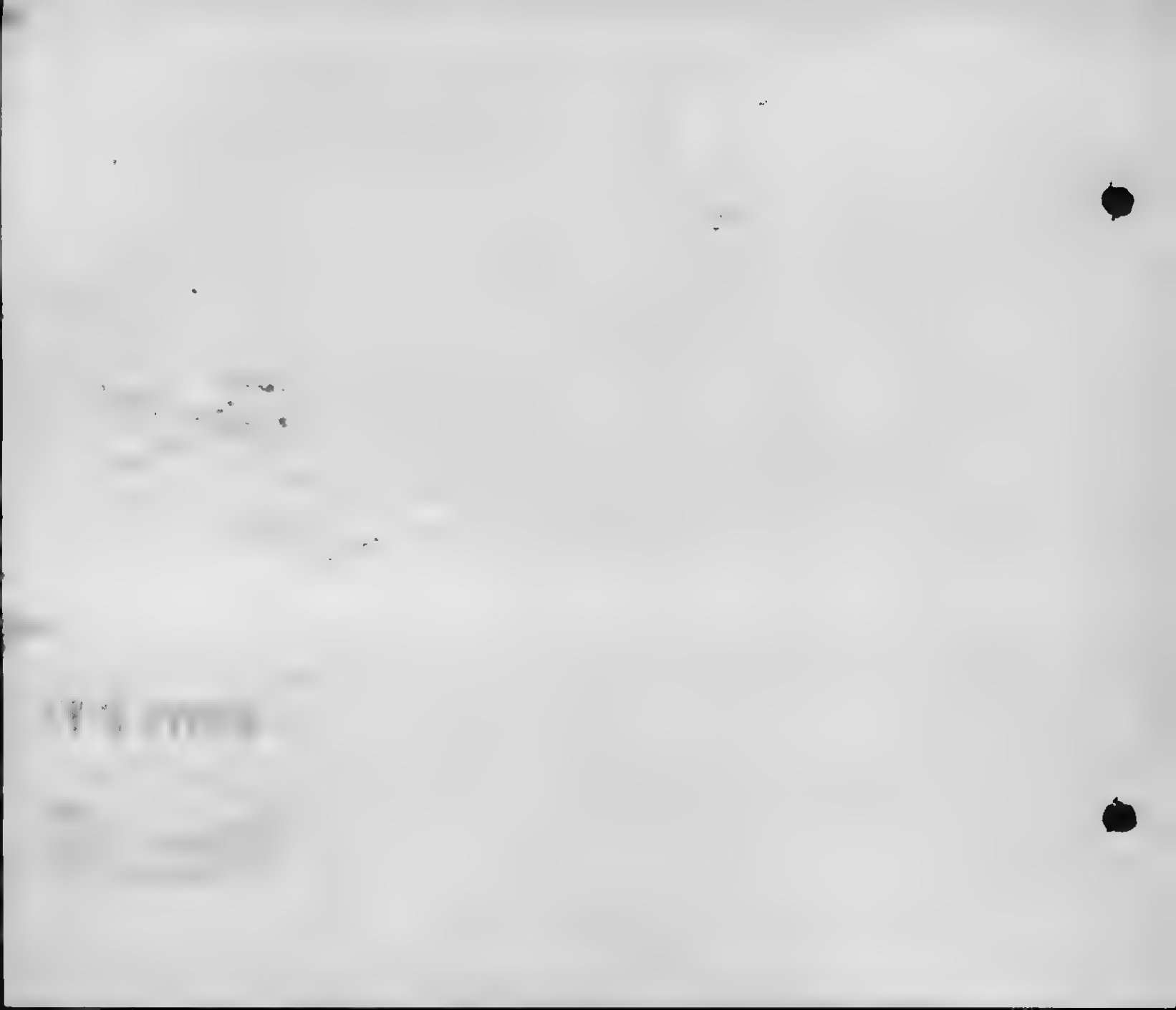
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 287

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>St Mary's</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>St Mary's</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Leonardtown</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Leonardtown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>Rt. 1</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Joseph</i>	(Middle) <i>W.</i>	(Last) <i>Neel</i>	(Month) <i>Feb</i> (Day) <i>16</i> (Year) <i>1955</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married Oct 16-1948</i>	8. DATE OF BIRTH: <i>4/8</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>laborer State road</i>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <i>48</i> yrs. IF UNDER 1 YEAR: Months <i>4</i> Days <i>18</i> IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country): <i>Maryland St Mary's Co.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>William F. Neel</i>		14. MOTHER'S MAIDEN NAME: <i>Agnes F. Neel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>W. F. Neel, Leonardtown Md</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>716.0 Immediate cause (a) <i>2nd degree burns of entire body</i></p> <p>Antecedent cause(s) (b) <i>none</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		<p>Immediate</p>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>home</i>)	21c. (City or town) (County) (State) <i>Leonardtown St. Mary's Md</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2 16 55 4 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>burned in house fire</i>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>John C. Mott</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2/16/55</i>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>burial</i>	DATE THEREOF: <i>Feb 18 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>St. John's</i>
LOCATION (City, town, or county) (State): <i>Holly Wood Md</i>	24. FUNERAL DIRECTOR: <i>John C. Mott</i>	ADDRESS: <i>Leonardtown Md</i>
DATE REC'D BY LOCAL REG. <i>Feb 17/55</i>	REGISTRAR'S SIGNATURE: <i>John C. Mott</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1955

CERTIFICATE OF DEATH

01942

Item 9 Film 6178 3-9-55 et

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St Mary's</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u> OR TOWN <u>Leonardtwn</u> LENGTH OF STAY (in this place) <u>8 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St Mary's Hospital</u>		STATE <u>Maryland</u> COUNTY <u>St Mary's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural California</u> OR TOWN <u>Rural California</u> STREET ADDRESS (If rural give location) <u>/</u>	
3. NAME OF DECEASED: (Type or Print) <u>Mamie</u> (First) <u>Otterback</u> (Middle) <u></u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 11</u> <u>1955</u>	
5. SEX <u>Female</u> 16 COLOR OR RACE <u>White</u> 7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH <u>Sept. 19, 1879</u> 9 AGE last birthday IF UNDER 1 YEAR IF UNDER 75 MRS. <u>76</u> 75 yrs <u>4</u> Months <u>14</u> Days <u>4</u> Hour <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME: <u>Wallaceeson Curry</u>		14. MOTHER'S MAIDEN NAME: <u>Francenia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Type, no, or unk.) (If Yes, give war or dates of service) <u>***</u>		16. SOCIAL SECURITY NO. <u>*****</u> 17. INFORMANT & ADDRESS: <u>Mrs Oran R. Wilkerson Calif. Md.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Compensatory Heart Failure</u>		<u>3 months</u>	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Heart Disease</u>		<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1951, to <u>Feb. 11</u> , 1955, that I last saw the deceased alive on <u>Feb 12</u> , 1955, and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>W. C. Boyd</u>		DATE SIGNED <u>2/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/14/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Jos. C. Mattingley Leonardtown, Md.</u>	
REGISTRAR'S SIGNATURE <u>R. F. Locke</u>			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

01943

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1956

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St Mary's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St Mary's</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>	LENGTH OF STAY (in this place) <u>2 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St Mary's Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>Infant</u> (Middle) <u>Stone</u> (Last) <u>Stone</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 20, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED DIVORCED (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Feb. 18, 1955</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. PLACE OF BIRTH (State or foreign country): <u>Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph F. Lord</u>		14. MOTHER'S MAIDEN NAME: <u>Elsie Elizabeth Johnson</u>	
15. CEASED EVER IN U.S. ARMED FORCES (If Yes, give war or dates of service):		16. INFORMANT & ADDRESS: <u>Joseph F. Stone Leonardtown, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>76.5</u>		DUE TO <u>Cerebral (intracranial hemorrhage) & D.</u>	
ANTECEDENT CAUSE (B)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Premature baby - birth wt 3-3"</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>Mechanville, Md 2/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		LOCATION (City, town, or county) (State) <u>Leonardtown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/28/55</u>		REGISTRAR'S SIGNATURE <u>Robt. Z. Lusk</u>	
24. FUNERAL DIRECTOR <u>John C. Mattingly</u>		ADDRESS <u>Leonardtown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1957
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01944
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Saint Mary's		MARYLAND		STATE Maryland COUNTY Saint Mary's			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
TOWN (Rural) Hollywood				Hollywood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				Sandy Bottom			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Lewis William Sween				February 14 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 12/25/1916	
				9. AGE last birthday: 38 yrs.		10. IF UNDER 1 YEAR: Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
U. S. Navy				Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Lawrence Sween				14. MOTHER'S MAIDEN NAME: Minette Gyndolyn Harring			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes				16. SOCIAL SECURITY No.: Present		17. INFORMANT & ADDRESS: Navy Records;; Patuxent River, Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>self-sanguination</i>						15 min	
Antecedent cause(s) (b) <i>shot gun wound of neck</i>						15 min	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: none							
19a. DATE OF OPERATION: none				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home		21c. (City or town) (County) (State)			
Sandy Bottom, St. Mary's, Md.							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: 2 14 55 P. M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Accidentally shot handling gun.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <i>John Sween</i>				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED: 2/15/55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 2/18/1955		NAME OF CEMETERY OR CREMATORY: Arlington National Cem.		LOCATION (City, town, or county) (State): Arlington, Virginia	
DATE REC'D BY LOCAL REG. 2/16/1955		REGISTRAR'S SIGNATURE: <i>P. B. Robinson, M.D.</i>		24. FUNERAL DIRECTOR: P.B. Robinson		ADDRESS: Leonardtown, Maryland.	

Local



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01945
Reg. Dist.

No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY ST. MARY'S		MARYLAND		STATE MARYLAND COUNTY ST. MARY'S			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN RURAL DRAYDEN		LIFE		TOWN RURAL DRAYDEN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:		(First) DALLAS		(Middle) E.		(Last) TAYLOR	
(Type or Print)							
4. DATE OF DEATH		(Month) FEB. 17,		(Day) 19		(Year) 55	
5. SEX:		6. COLOR OR RACE		7. SINGLE. MARRIED. WIDOWED. DIVORCED.		8. DATE OF BIRTH:	
MALE		COLORED		WIDOWED		APRIL 14, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		LABORER		10b. KIND OF BUSINESS OR INDUSTRY:		FARM	
11. BIRTHPLACE (State or foreign country):		MARYLAND		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
FRANK TAYLOR				UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
***				*****		ANNIE TAYLOR DRAYDEN, MARYLAND	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
177X Immediate cause (a) Carcinoma of prostate						2 yrs	
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
1953		adenocarcinoma of prostate					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
now		now		now			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
now		M.					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER			
John L. Law				DEPUTY MEDICAL EXAMINER			
				ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
BURIAL				2-21-53		ST. MARKS	
LOCATION (City, town, or county) (State)				24. FUNERAL DIRECTOR			
VALLEY LEE, MD.				JOS. C. MATTINGLEY			
DATE REC'D BY LOCAL REG.				ADDRESS			
Feb 19/55				LEONARDTOWN, MD.			

RECEIVED
BUREAU OF THE ARMY
WASHINGTON, D. C.

BUREAU V. S.

FEB 28 1905

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1959

CERTIFICATE OF DEATH

Reg. Dist. No. 281

01946

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Patuxent River				TOWN Lexington Park		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		U. S. Naval Air Station Infirmary		STREET ADDRESS		(If rural give location)	
50				593 Chinlee Drive			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
John		David		WILLIS			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
Male		Caucasian		Single		5 February 1955	
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
yrs. Months Days Hours Min.		Maryland		Maryland		U. S.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		15. INFORMANT & ADDRESS:		16. SOCIAL SECURITY NO.	
John Henry WILLIS		Mary Agatha BISCOE		Mrs. Mary Agatha WILLIS, 593 Chinlee Dr., Lexington Park, Maryland			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		19. MEDICAL CERTIFICATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
7 No		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4 hrs	
768.0		(A) SEPTICEMIA, Puerperal					
IMMEDIATE CAUSE		DUE TO					
ANTECEDENT CAUSE (S)		(B)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on , 19 , and that death occurred at 6:32PM. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
S. CASSARA, LT MC USNR		M. D. INF, PAX RIV MD.		2 Feb 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		7 Feb 1955		U. S. Naval Hospital		Bethesda, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Feb. 8. 55		P. G. Bern					

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2025271405

RECEIVED
FEB 8 1935
BUREAU V. S.